South Dakota Family Planning
Department of Health

CLIENT INFORMATION AND INFORMED CONSENT FORM

CHART #: _____

NAME: _____ Birthdate: _____

STREET ADDRESS: _____ APARTMENT NUMBER: _____

CITY: _____ STATE _____ ZIP CODE: _____

HOME PHONE #: _____ CELL PHONE #_____ WORK PHONE#: _____

EMPLOYER: _____ SOCIAL SECURITY #: _____

NAME OF SCHOOL IF YOU ARE A STUDENT: _____

CIRCLE ONE: SINGLE MARRIED LIVING TOGETHER SEPARATED DIVORCED WIDOW

CIRCLE ONE OR MORE: WHITE AMERICAN INDIAN BLACK ASIAN PACIFIC ISLANDER

ARE YOU HISPANIC? YES NO

PLEASE CHECK ALL THE WAYS WE MAY CONTACT YOU

CALL HOME ___ CALL CELL ___ CALL WORK ___ MAIL (RETURN ADDRESS) ___ MAIL (PLAIN ENVELOPE) ___

DO YOU HAVE CALLER ID? YES ___ NO ___ DO YOU WANT IT BLOCKED? YES ___ NO ___

LEAVE MESSAGE WITH _____ PHONE #: _____ RELATIONSHIP: _____

LEAVE MESSAGE ON ANSWERING MACHINE YES ___NO ___ E-mail YES ___NO ___ Address _____

PLEASE LIST WHO TO CONTACT IN CASE OF EMERGENCY (MUST BE PARENT OR GUARDIAN IF UNDER 18)

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

19 OR YOUNGER – HAVE YOU EVER TALKED WITH YOUR PARENT, GUARDIAN, OR OTHER ADULT MEMBER ABOUT WHETHER OR NOT TO HAVE SEX? YES ___ NO ___

DO YOUR PARENTS/GUARDIAN KNOW THAT YOU ARE COMING TO FAMILY PLANNING? YES ___ NO ___

INSURANCE INFORMATION AND/OR MEDICAID NUMBER:

INSURANCE/MEDICAID NUMBER: _____ PRIMARY CARE PHYSICIAN: _____

POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER EMPLOYER: _____

COMPANY NAME: _____ POLICY#: _____ GROUP#: _____

ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP

I authorize SD Family Planning Program to release medical information necessary to determine benefits payable under this claim by insurance or other third party payer. I authorize benefits to be paid directly to _____ _____. I understand I am financially responsible for this bill regardless of insurance coverage. This release of medical records information is valid for a period of one year from the date I sign this document.

Signature_____ **Date**_____

For Office Use Only
Insurance will cover BC YES ___ NO ___

INCOME DATA

RIGHTS AND RESPONSIBILITIES

1. I agree to provide all papers (supporting documents) needed.

2. I know the Civil Rights Law prohibits the program from denying me benefits based on my race, color, national origin, gender, religion, age, disability, political beliefs, except where this is restricted by law.

3. I understand that if I do not tell the truth in program applications, I may face criminal and/or civil prosecution, under state and/or federal law, I may have to pay for services received.

4. I understand I must tell the program if any facts in my application for the program change, i.e. income or family size.

5. I declare all facts on this form are true to the best of my knowledge.

INFORMED CONSENT FOR FAMILY PLANNING SERVICES

I understand that there are certain hazards and risks connected with all forms of medical treatment and care, and, with this knowledge, I hereby consent to receiving medical and related services from staff of the South Dakota Family Planning Program.

I also understand that my medical services and records will receive confidential treatment. I understand my Family Planning medical records can be shared with other South Dakota Family Planning clinics as necessary. My medical records can be disclosed to others only with my written consent, or, without my consent for either child abuse reporting purposes or as otherwise required by law. If tests are taken for any sexually transmitted diseases, reporting of positive results from those tests to public health agencies may be required by law.

I hereby certify that I have read and understand the above consent.

Signature of Client _____ Date _____

Signature of Witness _____ Date _____

FOR OFFICE USE ONLY

Family Size: _____ Annual Income: _____

Pay Category:_____ Expiration Date:_____

Proof of Income: Pay stubs _____Income Tax Return _____ Other _____

_____

Staff Signature:_____ Date: _____

FOR OFFICE USE ONLY

Family Size: _____ Annual Income: _____

Pay Category:_____ Expiration Date:_____

Proof of Income: Pay stubs _____Income Tax Return _____ Other _____

_____

Staff Signature:_____ Date: _____